STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

June 1, 2005

Dennis Smith, Director
Centers for Medicare and Medicaid Services
Center for Medicaid and State Operations
Mail Stop S2-26-12
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Mr. Smith:

As with most states in the nation, Michigan has been faced with the challenge of providing Medicaid benefits to a growing number of eligibles in an environment of diminishing state resources. To confront the issues associated with this test, the State of Michigan has developed a demonstration project under section 1115 of the Social Security Act. Entitled "Modernizing Michigan Medicaid," Michigan seeks to enlist the assistance of the federal government in modifying its Medicaid program using the flexibility afforded under a section 1115 waiver.

In a speech to the National Governor's Association, Department of Health and Human Services Secretary, Michael Leavitt stated, "If we don't do something, people in this country who are currently being served by Medicaid will lose their coverage." Michigan has now reached that point of which Secretary Leavitt warned. The state is not able to sustain Medicaid benefits for all those currently eligible for the program, nor does it have the fiscal capacity to support the projected eligible population for the near future if action is not taken. Medicaid enrollment in Michigan has reached a number heretofore unseen, nearly 1.5 million beneficiaries. This number is expected to grow by an additional 70,000 beneficiaries in the coming fiscal year.

On May 20, 2005, Secretary Leavitt established an advisory commission for Medicaid reform. In doing so, he noted that, "For generations, Medicaid has served the health care needs of the truly needy in America, but today the program is no longer meeting its potential. It is rigidly inflexible and inefficient, and worst of all, is not financially sustainable." The waiver proposal we are submitting will allow Michigan the flexibility necessary to continue providing benefits for those persons currently eligible, and enable the state to cover those most vulnerable citizens who will need Medicaid's assistance in the coming years.

In the spirit of Secretary Leavitt's agenda to make state Medicaid programs flexible enough to meet the needs of the currently and potentially eligible populations, we are looking forward to working with the CMS staff in crafting Michigan's Medicaid program for the future. The contact person on my staff for this project is Susan Yontz. You may reach her at (517) 241-4477 or by e-mail at yontzs@michigan.gov.

Sincerely,

Paul Reinhart, Director
Medical Services Administration

cc: Janet D. Olszewski, Director, MDCH
Wanda Pigatt-Canty, Project Officer
Cheryl Harris, Region V
Cynthia Garraway, Region V
Dell Gist, Region V

State of Michigan

Modernizing Michigan Medicaid

1115 Demonstration Application

June 1, 2005

Michigan Department of Community Health

Medical Services Administration

Jennifer M. Granholm, Governor

Janet D. Olszewski, Director

Modernizing Michigan Medicaid

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ATTACHMENTS:

I. STATEMENT OF PURPOSE

The State of Michigan, Department of Community Health (DCH), proposes a demonstration waiver under the authority of section 1115 of the Social Security Act. Entitled Modernizing Michigan Medicaid, the purpose of the waiver is to achieve sustainability of Medicaid coverage for the state's most vulnerable populations using the flexibility afforded under section 1115 of the Act.

On March 15, 2005 in a speech to the American Medical Association, Health and Human Services (HHS) Secretary, Mike Leavitt, stated that, "[HHS] must give states the flexibility to construct sustainable [Medicaid] programs."1 In his "Modernizing Medicaid" speech the following day he reiterated the same theme in stating, "We want to spur innovation and partner with states to make Medicaid more sustainable so it continues to serve America's most vulnerable people."2 With this waiver application, Michigan is proposing a broad-based Medicaid reform initiative that is completely supportive of and compatible with the Secretary's agenda. It will allow the state the flexibility necessary to control program costs while also protecting the vulnerable by maintaining coverage for all currently eligible individuals. The State of Michigan looks forward to working with the Centers for Medicare and Medicaid Services (CMS) in crafting a solution to the Medicaid sustainability issue that is facing nearly all states.

This document is divided into sections that contain information supporting the various components of the waiver proposal. The Current Environment section discusses Michigan's current economic environment and the resulting impact on the state budget and Medicaid enrollment. Section III, the Waiver Description, provides information related to three aspects of the proposal. First, it identifies the eligibility groups that will be impacted under the waiver. Second, it describes changes to the benefit package that would be offered under the demonstration. And finally, it outlines additional program modifications the state seeks in order to sustain Medicaid coverage for its beneficiaries. The Demonstration/Hypothesis is discussed in section IV, and section V provides narrative of the budget accompanying the waiver proposal. Public Input, section VI, describes steps taken by the state to invite public participation in the demonstration project. Waivers and Authorities Requested are listed in section VII, and evaluation of the waiver is outlined in section VIII.

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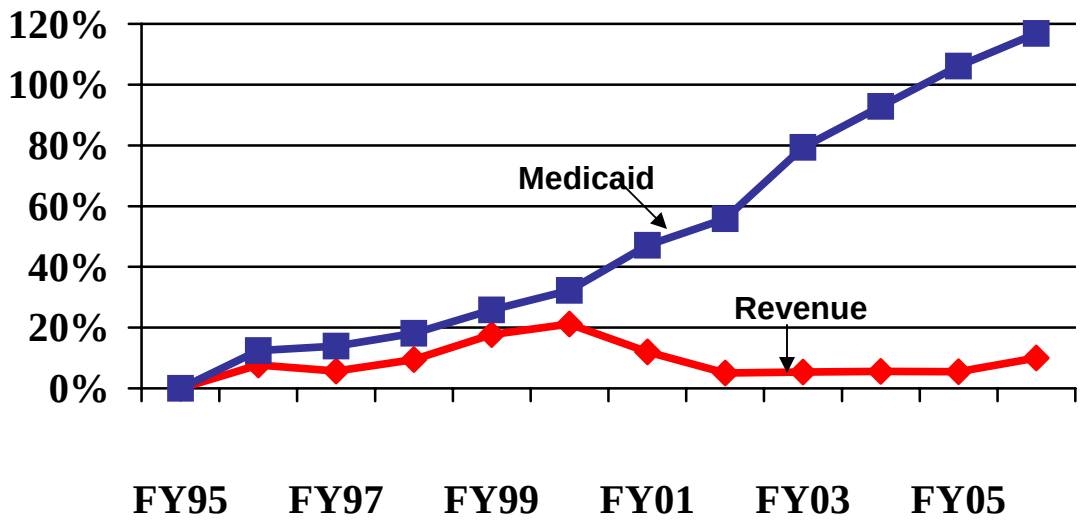
[1] Mike Leavitt, Secretary of Health And Human Services, Address to the American Medical Association, March 15, 2005.

[2] Leavitt, *Modernizing Medicaid,"* March 16, 2005.

II. CURRENT ENVIRONMENT

In Michigan, the cost of operating the Medicaid program within the confines of its existing structure and the current state budget environment has become unsustainable. State revenues have consistently declined since 2000, while Medicaid enrollment and expenditures have increased dramatically; the gap between revenues and costs has grown wider each year. Since 1994, Medicaid costs have increased by nearly 110 percent, and state revenues have remained virtually stagnant for the same time period. The Michigan Medicaid program in 2005 is subsisting on revenues equivalent to those realized by the state in 1995 (Figure 1)[3]. Recent revenue projections by the state's financial leaders indicate there are no significant signs of improvement in the near future.

Figure 1 – The widening gap between Medicaid expenditures and revenue



Michigan's budget and growing Medicaid population has been exacerbated by the state's high unemployment rate. According to statistics posted by the United States Department of Labor for February 2005, Michigan had the highest unemployment rate in the nation at 7.5%[4]. High unemployment has undoubtedly contributed to the number of uninsured in Michigan, and it is likely

[3] Michigan Department of Community Health, Modernizing Michigan Medicaid, p. 2 (February 2005).

[4] United States Department of Labor, Bureau of Labor Statistics, February 2005.

correlated to the growing number of individuals seeking healthcare coverage through Medicaid and other public assistance programs in the state. In a February 2005 report for the National Governors Association, Vernon Smith and Greg Moody noted that without Medicaid, the number of uninsured in the country would have been much larger during the country's recent economic downturn.[5] This theory has played out in Michigan over the last 10 years, as evidenced by the state's spiraling Medicaid population compared with a constant number of uninsured in the state.

Representative of the trend toward government assisted healthcare, Medicaid has become the largest single health care program in America.[6] In Michigan, the mounting number of Medicaid enrollees has led to the program requiring an ever-growing percentage of the state general fund revenues. In 2004, the Medicaid program consumed 25% of general fund revenue, and it is projected to increase to 26% in 2006. In fact, this increase in general fund consumption would have been even more significant had Governor Granholm not dedicated 100% of a new state cigarette tax to Medicaid. The rising amount of general fund revenue committed to Medicaid is also forcing crowd-out of other important state funded programs, an unfortunate trend that will continue unless new cost containment initiatives are implemented.

Despite the growth in caseload, the Michigan Medicaid program has been able to hold the rate of growth in per beneficiary spending to a level far below commercial health insurers; however, caseload growth has increased total spending. The Medicaid caseload has grown virtually every month over the last four years and now stands at 1.45 million, well above the previous record of 1.2 million set in 1994. This caseload growth increased total spending in fiscal year 2004 to $7.1 billion, a $550 million increase over fiscal year 2003. Trends indicate that enrollment will jump to over 1.5 million in the next year, which will result in even greater expenditures necessary to cover the additional enrollees. Recent program data show that Medicaid pays for nearly 40 percent of all births in Michigan, and two thirds of the individuals receiving long-term-care services. Currently one out of every six Michiganians receives health care through public programs. These numbers will undoubtedly increase given the caseload trend and unemployment figures.

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[5] Vernon K. Smith and Greg Moody, *Medicaid in 2005:Principles & Proposals for Reform,* February 2005.

[6] Ibid.

Michigan has taken action to counterbalance the strain that caseload growth and service cost have placed on the system. Historically, this state has been a leader in aggressively pursuing cost control initiatives for its Medicaid program. The majority of Michigan's Medicaid population has been enrolled in managed care plans since the state's 1915(b) waiver was initiated in 1996 to institute "value purchasing". Through managed care, the state has been able to increase access to care, control costs, and improve the quality of services provided for its beneficiaries. Managed care has also engendered predictability in program costs through the capitated reimbursement methodologies associated with this service delivery mechanism. Of the nearly 1.5 million Medicaid beneficiaries in Michigan, 93.1% of the mandatory population is enrolled in managed care.

In addition to the cost effective strategies associated with managed care, Michigan has also led the way in state Medicaid savings for pharmacy services. No state has been more aggressive than Michigan in pursuing strategies aimed at reducing the skyrocketing costs associated with its pharmacy benefit. In February 2002, Michigan introduced its Preferred Drug List as a means to provide the most efficacious pharmaceutical products to its Medicaid beneficiaries. Through a State Plan amendment, Michigan has implemented a supplemental rebate program, working with pharmaceutical manufacturers to obtain additional rebates for some drugs covered by Medicaid to offset the high cost of pharmaceutical products. Michigan spearheaded a multi-state effort so that other states could participate and realize the savings through supplemental rebate program as well. In addition, Michigan has implemented Maximum Allowable Cost (MAC) pricing to save money for the program, and strongly encourages the use of generic products. As a result of these initiatives, Michigan had the second lowest Medicaid pharmacy costs in the nation on a per person basis.

Despite these and other cost saving initiatives, Michigan's fiscal realities require a close examination of the Medicaid program and how the state can continue providing benefits to all groups currently eligible for them in the state. Clearly, the state must take immediate action or risk having to take more draconian measures, reducing services and eligibility to a greater number of individuals. Michigan's governor, Jennifer Granholm, is committed to protecting the state's most vulnerable citizens, and preserving the Medicaid program is one of her top priorities. To realize this, she has proposed that the state's Medicaid program reinvent itself through the assistance of a section 1115 demonstration wavier. In partnering with the federal government, the state seeks to stem the growth of Medicaid expenditures while prioritizing coverage for those who need it most.

III. WAIVER DESCRIPTION

The fiscal and political environment in Michigan is such that unprecedented steps must be taken to sustain Medicaid benefits for the individuals now receiving them. Because of its commitment to preserving eligibility and high quality benefits for individuals currently covered by Medicaid, the State of Michigan is seeking approval through the authority and flexibility provided under section 1115 to modify its program in a fashion atypical of demonstrations historically proposed by other states.

Although consistent with the spirit of other states' demonstration programs, Michigan is submitting this waiver application in the interest of sustaining its existing program and projected caseload. Using the demonstration to make program modifications as opposed to eligibility expansion typical of other 1115 waivers, Michigan hopes to continue offering a quality health care benefit to its current populations while providing coverage to the 70,000 new individuals it is projected will qualify for Medicaid in fiscal year 2006 under Michigan's existing eligibility rules. The state believes that with approval of this proposal, it will be successful in protecting its most vulnerable citizens while partnering with the federal government toward the goal of "modernizing Medicaid." Failure to approve these initiatives will result in a need to further reduce benefits and eliminate eligibility groups.

The following subsections outline proposed changes to eligibility and enrollment, program benefits and reimbursement under the Modernizing Michigan Medicaid Waiver.

A. ELIGIBILITY and ENROLLMENT

The State of Michigan recognizes the value of good health to the quality of life for its citizens. In acknowledgement of this value and in recognition of the right of all persons to have access to health care, the state has crafted its Medicaid program under the State Plan to provide medical assistance to a very broad scope of low-income individuals.

Over the years, Michigan has expanded Medicaid coverage to many groups and income levels over and above those required by federal statute and regulations. For example, Michigan has covered the following groups who fall above minimum federal requirements for Medicaid eligibility:

- Poverty-level children under age one and pregnant women with income up to 185% of the federal poverty level (FPL);
- Poverty level children under age 19 with family income up to 150% of FPL;

- Low-income women diagnosed with breast and cervical cancers; and
- Disabled individuals through the Ticket to Work initiative.

Michigan has also partnered with the federal government using SCHIP funds to provide health care coverage to additional low-income citizens not qualifying for Medicaid. For example:

- Children with family income from 150% to 200 % of FPL are covered by Michigan's stand-alone SCHIP program, MIChild.
- Michigan was one of the first states to cover unborns under its SCHIP program.
- With the approval of its section 1115 HIFA waiver, Michigan provides health care benefits to over 60,000 childless adults with income at or below 35% of the FPL through the Adult Benefits Waiver.

In total, Michigan supports over 30 categories of eligibility recognized by the federal government for Medicaid or SCHIP coverage, well above the requirements placed on the state in statute. Despite the fiscal responsibility the state bears for supporting all of these groups, Michigan remains dedicated to sustaining all of them, and this waiver application is a direct result of that commitment.

Staying true to this commitment as well as the Governor's vow to protect the state's most vulnerable citizens, Michigan proposes to effect a change in coverage for only two groups of adults currently receiving Medicaid coverage through optional categories of eligibility. The affected groups include individuals who are commonly referred to as caretaker relatives, as well as individuals who are 19 and 20 years of age. These individuals have countable income that is less than 133% of the AFDC level, and are a subset of the optional TANF-related coverage groups covered under Michigan's State Plan. Though not targeted for elimination under the waiver, these eligibility groups will be impacted by benefit modification in this demonstration. A description of the modified benefit is provided in Subsection B of the Waiver Description Section.

Based on trends in program enrollment data, it is estimated that on the anticipated effective date of this demonstration, there will be 10,700 enrollees who are 19 and 20 years old. It is also estimated that there will be 42,000 caretaker relatives who are enrolled in the Michigan Medicaid program at that time.

Enrollment Freeze

In an effort to manage the available Medicaid resources in a manner that would protect those who need medical assistance the most, Michigan seeks authority to freeze enrollment for enrollees who are 19 and 20 years of age. The State would continue to provide Medicaid coverage for currently enrolled individuals in this age group, but new 19 and 20 year-old applicants would not be enrolled in the program after September 30, 2005. Individuals eligible in this category would ultimately age out of the program.

Despite the age-out phenomenon inherent to this plan, there is also some residual benefit to freezing enrollment for this age group versus eliminating the category entirely. The enrollment freeze is designed to save program costs in the short term, but it will also retain the eligibility category in the event that Michigan's fiscal status improves. If such improvement occurs, the state would consider reopening enrollment for this age group, pending CMS approval.

The enrollment freeze will also allow the state to protect categories of individuals with less ability to provide health care coverage for themselves. If enrollment were not frozen for 19 and 20 year olds, it would be necessary for the state to consider totally eliminating other categories of eligibility.

It is important to note that Michigan has an alternative source of health care coverage for which some eligible 19 and 20 year olds might apply if Medicaid enrollment is frozen. The state currently has an approved 1115 HIFA waiver (Adult Benefits Waiver) through which health care benefits are provided to childless adults with annual income at or below 35 percent of the federal poverty level. It is likely that some of the individuals meeting the Medicaid eligibility criteria will also meet those established for the ABW.

Retroactive Enrollment

A major component of this proposed demonstration project is a request to waive the statutory requirement for three-months retroactive enrollment. The state seeks the ability to enroll individuals eligible for the program with an effective date retroactive only to the first day of the month in which application for Medicaid benefits is made. It is estimated that by changing the initial date of eligibility, Michigan will save nearly $12.3

million in state general fund dollars for fiscal year 2006, which also realizes approximately $16 million in savings for the federal government.[7]

All potential Medicaid eligibles would be subject to this provision of the demonstration.

B. COVERED BENEFITS

Under the proposed waiver, the state will provide a reduced scope of benefits to individuals covered by the waiver when compared to benefits offered under the State Plan to other Medicaid beneficiaries. However, the benefit package that is provided will be comparable to those offered through many commercial health insurance packages in the private sector.

Benefits

In its plan for Medicaid reform and sustainability, Michigan will offer a package of basic benefits comparable with those provided through commercial health insurance carriers. This new benefit package will be offered to the optionally covered non-pregnant, non-disabled adults (caretaker relatives and 19 and 20 year-olds). A description of the revised benefit package follows.

Modified Benefit Package

Under the waiver, Michigan will offer the demonstration population a benefit package less robust than that offered to traditional Medicaid beneficiaries. The benefit package will be comparable to services covered in the commercial insurance marketplace. It will meet all of the basic health care needs of enrolled individuals, but will not offer some additional optional services that will remain covered in the traditional Medicaid program under the state plan.

The revised benefit package for these non-pregnant, non-disabled adults **will not** include the following: hearing services, vision services, speech therapy, physical therapy, and occupational therapy. All beneficiaries covered under the waiver will continue to have access to physician services, inpatient and outpatient hospitalization services, behavioral health care and nursing facility level of care services.

[7] Michigan Department of Community Health, *Modernizing Michigan Medicaid*, February 2005.

Limitations on Covered Benefits and Cost Sharing

For the demonstration population, the state will impose limitations on some of the State Plan benefits it currently offers, as well as introduce a co-payment for emergency department services. The co-payment assessment for emergency room (ER) services will encourage appropriate utilization of the ER. The proposed benefit changes and co-payments are as follows:

- Inpatient hospitalization will be limited to 20 days per year
- Prescription drug coverage will be limited to four prescriptions per month per beneficiary
- All emergency room visits will require a $10 co-payment

Attachment A

A chart provides details of the proposed benefit package for the demonstration population compared to the benefits currently covered for traditional Michigan Medicaid beneficiaries.

C. MANAGED CARE RATE SETTING

In order to sustain coverage using a managed care delivery system, Michigan is seeking relief from regulations that require states to pay federally imposed rates to contracted MCOs. The state is asking that these requirements be suspended until such time that the state's fiscal status is improved. Without approval of this request, the Michigan Medicaid program is at risk of losing the capacity to provide services through managed care.

Because managed care has been proven to save the state and federal governments millions of dollars in the delivery of Medicaid benefits to beneficiaries, it is essential to the program that this benefit delivery system be sustained. If forced to return all of its beneficiaries to a fee for service delivery system, the state would have no alternative but to consider drastic cuts to covered benefits and/or optional populations. These types of cuts would be counterproductive to President Bush's initiative to reduce the nation's uninsured population.

In a report to the Michigan legislature, the Center for Health Program Development and Management at the University of Maryland, Baltimore County, concluded that the state would generate savings of $330 million in comparing estimated managed care costs for fiscal year 2006 to a fee-

for-service delivery system.8 This report also pointed out that the state would not only experience increased per member per month costs for beneficiaries, it would also incur increased administrative costs in shifting the administrative burden for operating the program back to the state from the MCOs. This would be necessary because the administrative infrastructure of the fee-for-service program was naturally diminished with the majority of program beneficiaries enrolled in managed care.

In addition to the state losing financial savings realized through managed care, Michigan's Medicaid population would suffer in other ways. Managed care assures that beneficiaries have access to both primary care and specialty services. Research has repeatedly demonstrated that insufficient provider participation in a fee for service Medicaid program results in a corresponding loss in access to services for its beneficiaries.9 Furthermore, quality of care assurances provided under a managed care system would almost certainly be compromised because a fee for service system of independent providers is unable to produce the same types of reporting measures that typically are required of and by MCOs.

With the aforementioned acknowledgement of the importance of managed care to the success of administering its Medicaid program, Michigan seeks approval for waiver of the procedures in regulations requiring actuarial soundness. In doing so, the marketplace will provide a laboratory for managed care rate setting and will help the federal government evaluate the effectiveness of the standards it has set.

D. ADMINISTRATION

This waiver will be administered using the same components and processes used to administer Michigan's traditional Medicaid program. Eligibility and enrollment for all beneficiaries will continue to be determined by the Michigan Department of Human Services (formerly the Family Independence Agency). Unless otherwise exempt, all beneficiaries of waiver services will be enrolled in one of the Medicaid Health Plans (MHPs) under contract with the Department to provide managed care services for Medicaid beneficiaries. Beneficiaries receiving services under

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[8] Center for Health Program Development and Management, *Michigan Medicaid: Relative Cost Effectiveness of Alternative Service Delivery Systems, April 2005.*

[9] Vernon K. Smith, and Linda Hamacher, *The Good Olde Days of Fee for Service Were Not So Good After All: Managed Care Has Made Things Better,* working paper, May 2003.

this waiver will have the same opportunities to enroll in the MHP of their choice, contingent upon availability in their area of residence, just as they would have without this waiver. If not enrolled in one of the MHPs, beneficiaries will receive benefits through the fee for service delivery system.

Pharmacy benefits provided under the waiver will be administered by the Department's contracted pharmacy benefit manager (PBM), currently First Health Services Corporation. The PBM will be responsible for tracking the number of prescriptions a waiver beneficiary receives so as not to exceed the number covered under the waiver.

IV. DEMONSTRATION/HYPOTHESIS

One purpose of the Michigan Medicaid Modernization demonstration waiver is to test whether Michigan can keep its uninsured population from growing when faced with decreasing government funding and an eroding commercial insurance base. A reduced benefit package for optional populations in the TANF category is one strategy for stemming the flight from commercial insurance. It is important to learn whether the lure of a broad-scope benefit package offered under the traditional Medicaid program has dissuaded low-income workers from enrolling in employer-sponsored commercial insurance programs when they are available to them.

A report by the Center for Studying Health Center Change noted that as the number of individuals losing health insurance in the country increased, the number of uninsured remained relatively stable, demonstrating the shift toward government provided benefits.[10] This frames an additional major strategy of this waiver, which is to stretch state government resources to cover an increasing number of persons qualifying for Medicaid. This recognizes the reality that the first strategy will at best slow down the flight of low income persons from commercial insurance.

A second demonstration opportunity is offered in this waiver package through the State's request for a waiver of actuarially sound rates for managed care organizations (MCOs). When the Medicaid program was created, all state programs were administered on a fee for service basis and federal regulations were built on creating maximum levels of reimbursement as a protection on federal funding. As MCOs evolved and managed care was integrated into programs as a primary service delivery model, the regulatory environment evolved as well. Initially, capitation rates were limited to expenditure proxies from the fee for service program commonly known as fee for service equivalents (FFSE). The increasing dominance of managed care has moved regulations to "actuarial soundness," a concept that establishes both minimum and maximum rates and often establishes a single acceptable level of reimbursement (with variances for risk adjusters like age and gender as a part of the system).

The current regulatory environment is problematic from multiple perspectives and that is cause for this request for waiver. By establishing minimum and maximum reimbursement levels, regulations offer states less flexibility than in any prior period and effectively limit the ability of states to manage and control expenditures. With balanced budget requirements and stagnant revenues,

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[10] Strunk, B. and Reschovsky, J. "Trends in U.S. Health Insurance Coverage, 2001-2003, Tracking Report No. 9," Center for Studying Health Systems Change (August 2004), accessed at www.hschange.org/CONTENT/694.

states are unable to manage Medicaid to effectively adjust to the financial conditions they face.

Limited flexibility is compounded by the inherent inflationary nature of actuarial soundness. This concept is built on formulaic methodologies that assume that historic health care cost increases will be repeated in the future making inflation a self-fulfilling prophecy. States are left with no ability to break this cycle and are simply captive to future cost increases. This is an extension of other financial principles in health care that feed a seemingly irresistible inflationary force. Health care financing is then captive to artificial markets and rate-setting methodologies that perpetuate inflation.

Michigan's demonstration is to develop other methodologies that break the inflationary cycle and maintain the effective delivery of health care services. Michigan will explore new approaches that incorporate the traditional principles and advantages of a true market economy. In the short term, given very constrained resources, Michigan requests suspension of the actuarial soundness requirement in order to maintain eligibility and benefit levels with the limited reductions proposed in the earlier description.

V. Budget

The budget that has been prepared for this initiative uses a format that is consistent with other 1115 waivers. Basic components include historical data to develop trend, without waiver cost projections, with waiver cost projections and a summary of cost effectiveness across the five-year life of the waiver. Because of the need to accommodate unique features that have been incorporated into this program, Michigan has developed and employed customized forms. Budget spreadsheets are included as Attachment C.

A. Historical Data

Historical data used to develop estimates of trend cover state fiscal years 2002 through 2004. Although some data are available for state fiscal year 2005, claim lag issues make it problematic to use this information. Claim and utilization data for the 2005 fiscal are therefore based on trends and other known factors that would impact costs.

With regard to managed care, the cost change per member per month from fiscal year 2004 to fiscal year 2005 is impacted by the new contract with Medicaid health plans that went into effect on October 1, 2004 (the beginning of the state fiscal year). For persons age 19 and 20 in the Group 2 Under 21 aid category, a 10% increase per member per month is employed due to the cost of a new child and adolescent health center outreach program built into rate cells that apply to these individuals. The increase for Caretaker Relatives is left at the standard rate increase of 7.5% because the new program does not impact the rate cells that cover this group. For other aid categories, a blended increase of 8.3% (7.5% regular + .8% for child and adolescent center outreach) is used.

Enrollment trend from 2004 to 2005 is based on historical experience. Fluctuations occurred with Caretaker Relatives resulting from a failed attempt to eliminate this aid category during fiscal year 2003. Note that total costs based on claims data for the fee-for-service group are high when compared to managed care because of the inclusion of long term care services.

B. Without Waiver

Enrollment trends are specific to the aid categories that are uniquely impacted by the changes presented in this waiver. For both the managed care and fee-for-service Medicaid population, the trend from fiscal year 2005 to 2006 is expected to be approximately 5%, dropping to 4% per year for the remaining four years.

Following a generally lower increase from fiscal year 2005 to fiscal year 2006, fee-for-service costs per member per month are projected to increase at a rate of 5% for all aid categories from 2007 to 2010. With regard to Medicaid health plans, the cost per member per month will increase by 12.5% from fiscal year 2005 to 2006 as a result of the federally mandated rate methodology, from which relief is being sought through this waiver. Efficiencies inherent in managed care, when compared to fee-for-service, result in a lower projected increase per member per month of 4% throughout the remainder of the waiver period.

C. With Waiver

Relief from application of a federally mandated rate methodology for developing health plan rates is a major component of the Modernizing Michigan Medicaid waiver. With this requirement waived, and in light of the 7.5% rate boost received by health plans when their new contracts became effective on October 1, 2004, it is assumed that no rate increase would occur from fiscal year 2005 to fiscal year 2006. For the remainder of the waiver period, PMPM trend will remain at 4%, the same as the trend for health plans without benefit of the proposed waiver.

The baseline cost PMPM for managed care in state fiscal year 2006 is therefore the same as the historical trend for FY 05. Note that enrollment is essentially the same as would occur without the waiver for the baseline data, but has some member months removed due to the freeze on enrollment for 19 and 20 year olds in the Group 2 Under 21 aid category. The aggregate fee-for-service trend in costs per member per month is derived from without waiver calculations.

To reflect the impact of enrollment and benefit changes that are included in this waiver, cost reductions are subtracted from baseline costs described in the preceding two paragraphs. For managed care, these savings are subtracted from trended costs with waiver of actuarial soundness factored in. With regard to fee-for-service, savings are subtracted from without waiver costs.

Note that the freeze on new enrollments for 19 and 20 year olds in the Group 2 Under 21 aid category reduces member months for both managed care and fee-for-service enrollment. As a result of the proposed freeze, enrollment of 19 and 20 year olds in this aid category is completely eliminated starting in fiscal year 2008. Elimination of retroactive eligibility reduces enrollment in fee-for-service, but not managed care since beneficiaries do not get retroactively enrolled into Medicaid health plans.

It should also be noted that trends commensurate with other sections of this budget are applied to savings calculations.

Note that the member months which are being eliminated as a result of the enrollment freeze for 19 and 20 year olds in the Group 2 Under 21 aid category are also removed in the calculations of savings that result from the elimination of certain benefits for caretakers and under 21s. Savings applicable to each of the reductions reflect the Governor's fiscal year 2006 proposed budget.

The "Net with Waiver" section in Attachments C – 5 and C – 6 reflect the baseline costs minus the member months and costs associated with the proposed enrollment and benefit changes. The net PMPM cost is a calculated number based on the result of reductions in member months and costs.

D. Concerns and Conditions

Many of the calculations presented in this budget are subject to approval of the Governor's Budget by the state legislature. Therefore, Michigan reserves the right to update and to make changes to this budget as appropriate. In addition, the following concerns and conditions will need to be addressed as additional details of this plan are developed:

1. Aggregate "without waiver" costs are based on assumptions using the best available paid claims and enrollment information. Unforeseen circumstances may develop, however, that would result in spending in excess of what is projected. Therefore, the state will not accept any suggestion that aggregate without waiver cost reflect a cap on Medicaid spending for the state.
2. All costs presented in this budget reflect paid claims and related sources of data. However, there are numerous out-of-system costs incurred by the Medicaid program in Michigan which are handled as gross adjustments and that could not be effectively distributed among the services and aid categories addressed by this waiver. Total Medicaid spending is therefore significantly higher that what is reflected in aggregate costs.
3. Among the largest "out of system" costs not included in this budget are payments for community mental health services, Medicaid Access to Care Initiative (MACI) payments to hospitals, Quality Assurance Supplement (QAS) payments to nursing homes, disproportionate share payments to hospitals, graduate medical education payments to hospitals, Medicare premiums for dual eligible beneficiaries and payments for home help services.
4. Adjustments have not been incorporated for the Medicare Part D benefit that will begin January 1 of 2006, and for pharmacy rebates.

VI. PUBLIC INPUT

The State has invited the public to participate and comment on this proposed demonstration waiver in compliance with State Medicaid Director Letter #02-007. Opportunity for input was provided through the following initiatives:

- A public meeting was held on May 4, 2005 during which waiver content was presented and discussed with attendees. Notice of the meeting was placed on the Department's website and in newspapers throughout the state, consistent with the Department's customary public notice process.

- Waiver-related information was placed on the Michigan Department of Community Health website with a link to an electronic mailbox for submission of comments. Waiver-related comments and questions will be posted on the Department's website for public viewing.

- The public is invited to comment on waiver content during legislative hearings in the state budget process for the Department's budget for the next fiscal year since waiver components are included in the Governor's budget for fiscal year 2006.

- Notice of the waiver and the opportunity for comment was published in newspapers throughout the state consistent with requirements for notices related to State Plan amendments.

- Opportunity for comment was provided at the state's Medical Care Advisory Committee meeting.

- Eligibility and covered benefits policy for the waiver will be promulgated through the formal notice and comment process in accordance with the State's administrative procedure requirements.

- Tribal consultation requirements were met by presenting the waiver to the State's 12 federally recognized tribes at the April 2005 quarterly Tribal Health Directors Association meeting. Letters informing Tribal Chairs of the intent to submit the wavier were mailed to each Chairperson along with a copy of the Department's concept paper. The date, time and location of the planned Public Meeting were provided in the letter. Opportunity for an additional in-person or conference call meeting was also offered.

VII. WAIVERS and AUTHORITY REQUESTED

In order to implement the plan for Modernizing Michigan Medicaid, the State of Michigan will need to obtain waiver authority pursuant to section 1115(a)(1) of the Social Security Act for the following:

Amount, Duration, and Scope of Services ***1902(a)(10)(B)***

To enable the state to redefine the benefit package for the demonstration populations covered under the waiver.

Comparability of Services ***1902(a)(10(B)***

To enable the state to impose different cost sharing requirements for populations covered under the demonstration than those covered under the state plan.

To enable the state to offer benefits different than those offered to other populations covered under the state plan.

Retroactive Eligibility ***1902(a)(34)***

To enable the state to restrict the Medicaid eligibility begin date to the first day of the month in which the application for benefits is made.

Actuarial Soundness ***1902(a)(4)(A)***

To enable the state to operate its Medicaid program in a manner that is proper and efficient, the state seeks to temporarily suspend the requirement to pay actuarially sound rates to its contracted managed care plans.

Cost Sharing ***1902(a)(14)***

1916(a)(2)(D)

To enable the state to charge co-payments for emergency room services for optional populations covered under waiver authority.

EPSDT Requirements ***1902(a)(43)***

To enable the state to freeze enrollment for 19 and 20 year olds as well as reduce the optional benefit package for this optional population.

VIII. EVALUATION

The success of this waiver will be evaluated based on the state's ability to maintain its mounting caseload without further cuts to benefits or covered optional populations. It is anticipated that through this demonstration the state will be able to preserve its caseload until it enjoys an economic resurgence. The state will closely monitor caseload and expenditure trends in carrying forward with this demonstration. In order to study the effect of a reduced benefit package on the substitution of government-supported health care for coverage available to workers through employers and commercial insurance packages, the state will monitor insurance trends as well as caseload, particularly for individuals in the 19 to 64 year old age group. National trend data will be compared to that available for the state of Michigan to examine if the trend toward substitution continues over the waiver period.

Because a significant portion of this demonstration relies on the waiver of actuarial soundness requirements, the state will closely monitor the quarterly financials of the contracted MCOs to ensure their viability. One of the additional factors that the state will monitor is continued access to care for beneficiaries through the MCOs.

Covered Benefits

Modernizing Michigan Medicaid

State Plan Services	**Existing Medicaid Benefit in Michigan**	**MMM Waiver Covered Benefits for 19 & 20 year olds and Caretaker Relatives**
Inpatient Hospital Medical/Surgical	Covered	Covered- Limited to 20 inpatient days
Outpatient Hospital	Covered	Covered
RHC & FQHC Prospective Payment System Rate	Covered	Covered
Lab & X-ray	Covered	Covered
Nurse Practitioner	Covered	Covered
Nursing Facility & Home Health for Beneficiaries 21 and Older	Covered	Covered
EPSDT for beneficiaries Under 21	Covered	EPSDT services limited with waiver
Family Planning	Covered	Covered
Physician	Covered	Covered
Nurse Midwifes	Covered	(Pregnant women are not covered in this group since they would be eligible under Healthy Kids.)
Maternity Services	Covered	(Pregnant women are not covered in this group since they would be eligible under Healthy Kids.)
Ambulance	Covered	Covered
Podiatrist	Covered ($2 Copay)	Covered ($2 co-pay)
Optometrist	Covered ($2 Copay)	Non-Covered
Chiropractor	Covered ($1 Copay) ***Will change to non-covered with State Plan Amendment***	***Will change to non-covered with State Plan Amendment***
Other Practitioner	Covered	Covered
Dental	Covered for Under 21 (Nominal Co-pay)	Non-covered for over 21
Physical Therapy	Covered	Non-covered
Occupational Therapy	Covered	Non-covered

Covered Benefits

Modernizing Michigan Medicaid

State Plan Services	**Existing Medicaid Benefit in Michigan**	**MMM Waiver Covered Benefits for 19 & 20 year olds and Caretaker Relatives**
Speech, Hearing & Language Disorders	Covered	Non-covered
Prescribed Drugs	Covered ($1 & $3 Co-payments)	Covered – Limited to four prescriptions per month ($1 & $3 co-payments)
Medical Supplies	Covered	Covered
Dentures	Non-covered for over age 21 and over	Non-covered for age 21 and over
Prosthetic/Orthotics	Covered	Covered
Eyeglasses	Covered	Non-covered
Hearing Aids	Covered ($3 Copay)	Non-covered
Diagnostic	Covered	Covered
Rehabilitative	Covered	Covered
ICF for Mentally Retarded	Covered	Covered
Inpatient Psych for Beneficiaries Under 21	Covered	Covered
Nursing Facility for Beneficiaries Under 21	Covered	Covered
Hospital Emergency Department Services	Covered	Covered- $10 co-payment for all emergency room visits
Personal Care	Covered	Covered
Transportation	Covered	Covered
Case Management	Covered	Covered
Hospice Care	Covered	Covered
Respiratory Care	Covered	Covered
Mental Health	Covered	Covered
Substance Abuse	Covered	Covered

Eligibility

Groups Impacted by Modernizing Michigan Medicaid Waiver

ELIGIBILITY	INCOME LEVEL		ASSETS	
	State Requirement % FPL	Federal Requirement % FPL	State Requirement	Federal Requirement
19 & 20 Year Olds	133% of AFDC payment standard (about 50% FPL)	133% of AFDC payment standard (about 50% FPL)	None	$2,000 single $3,000 couple
Caretaker Relatives	133% of AFDC payment standard (about 50% FPL)	133% of AFDC payment standard (about 50% FPL)	None	$2,000 single $3,000 couple

Attachment C - 1

Modernizing Michigan Medicaid
Budget Submission

Historical MCO

	FY 2002	FY 2003	FY 2004	FY 2005 (Projected)	Trend
Group 2 Under 21 - 19 & 20 year olds					
Member Months	58,763	71,260	86,389	103,667	
% Change		21.27%	21.23%	20.00%	20.83%
Average Eligibles	4,897	5,938	7,199	8,639	
Payments	$ 5,289,190	$ 6,647,822	$ 8,594,660	$ 11,344,951	
% Change		25.69%	29.29%	32.00%	28.99%
Cost PMPM	$ 90.01	$ 93.29	$ 99.49	$ 109.44	
% Change		3.64%	6.64%	10.00%	6.76%
Caretaker Relatives					
Member Months	335,309	293,220	310,343	325,860	
% Change		-12.55%	5.84%	5.00%	-0.57%
Average Eligibles	27,942	24,435	25,862	27,155	
Payments	$ 61,266,235	$ 55,538,197	$ 64,662,459	$ 72,987,751	
% Change		-9.35%	16.43%	12.88%	6.65%
Cost PMPM	$ 182.72	$ 189.41	$ 208.36	$ 223.98	
% Change		3.66%	10.00%	7.50%	7.06%
All Other Aid Categories					
Member Months	8,768,831	9,295,204	9,908,477	10,502,986	
% Change		6.00%	6.60%	6.00%	6.20%
Average Eligibles	730,736	774,600	825,706	875,249	
Payments	$ 1,338,204,857	$ 1,451,751,729	$ 1,653,595,983	$ 1,898,295,117	
% Change		8.49%	13.90%	14.80%	12.40%
Cost PMPM	$ 152.61	$ 156.18	$ 166.89	$ 180.74	
% Change		2.34%	6.85%	8.30%	5.83%
Total					
Member Months	9,162,903	9,659,684	10,305,209	10,932,513	
% Change		5.42%	6.68%	6.09%	6.06%
Average Eligibles	763,575	804,974	858,767	911,043	
Payments	$ 1,404,760,283	$ 1,513,937,748	$ 1,726,853,102	$ 1,982,627,819	
% Change		7.77%	14.06%	14.81%	12.22%
Cost PMPM	$ 153.31	$ 156.73	$ 167.57	$ 181.35	
% Change		2.23%	6.92%	8.22%	5.79%

Modernizing Michigan Medicaid
Budget Submission

Historical FFS

	FY 2002	FY 2003	FY 2004	FY 2005 (Projected)	Trend
Group 2 Under 21 - 19 & 20 year olds					
Member Months	32,618	38,511	44,512	51,189	
% Change		18.07%	15.58%	15.00%	16.22%
Average Eligibles	2,718	3,209	3,709	4,266	
Payments	$ 10,218,520	$ 10,936,866	$ 12,094,867	$ 13,909,097	
% Change		7.03%	10.59%	15.00%	10.87%
Cost PMPM	$ 313.28	$ 283.99	$ 271.72	$ 271.72	
% Change		-9.35%	-4.32%	0.00%	-4.56%
Caretaker Relatives					
Member Months	174,420	159,535	172,635	186,446	
% Change		-8.53%	8.21%	8.00%	2.56%
Average Eligibles	14,535	13,295	14,386	15,537	
Payments	$ 58,503,152	$ 55,097,626	$ 61,975,473	$ 68,941,516	
% Change		-5.82%	12.48%	11.24%	5.97%
Cost PMPM	$ 335.42	$ 345.36	$ 359.00	$ 369.77	
% Change		2.97%	3.95%	3.00%	3.30%
All Other Aid Categories					
Member Months	5,303,120	5,754,996	5,944,796	6,182,588	
% Change		8.52%	3.30%	4.00%	5.27%
Average Eligibles	441,927	479,583	495,400	505,308	
Payments	$ 2,907,113,500	$ 3,168,402,178	$ 3,265,596,113	$ 3,430,182,157	
% Change		8.99%	3.07%	5.04%	5.70%
Cost PMPM	$ 548.19	$ 550.55	$ 549.32	$ 554.81	
% Change		0.43%	-0.22%	1.00%	0.40%
Total					
Member Months	5,510,158	5,953,042	6,161,943	6,420,222	
% Change		8.04%	3.51%	4.19%	5.25%
Average Eligibles	459,180	496,087	513,495	535,019	
Payments	$ 2,975,835,173	$ 3,234,436,670	$ 3,339,666,452	$ 3,513,032,769	
% Change		8.69%	3.25%	5.19%	5.71%
Cost PMPM	$ 540.06	$ 543.33	$ 541.98	$ 547.18	
% Change		0.60%	-0.25%	0.96%	0.44%

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Modernizing Michigan Medicaid
Budget Submission

Without Waiver
Managed Care

	FY 2006	FY 2007	FY 2008	FY 2009	FY '2010	Total
Group 2 Under 21 - 19 & 20 year olds						
Member Months	114,033	120,875	125,711	130,739	135,968	627,327
% Change	10.00%	6.00%	4.00%	4.00%	4.00%	
Average Eligibles	9,503	10,073	10,476	10,895	11,331	
Payments	$ 14,039,377	$ 15,477,009	$ 16,739,933	$ 18,105,912	$ 19,583,354	$ 83,945,586
% Change	23.75%	10.24%	8.16%	8.16%	8.16%	
Cost PMPM	$ 123.12	$ 128.04	$ 133.16	$ 138.49	$ 144.03	
% Change	12.50%	4.00%	4.00%	4.00%	4.00%	
Caretaker Relatives						
Member Months	342,153	355,839	370,073	384,876	400,271	1,853,212
% Change	5.00%	4.00%	4.00%	4.00%	4.00%	
Average Eligibles	28,513	29,653	30,839	32,073	33,356	
Payments	$ 86,216,781	$ 93,252,070	$ 100,861,439	$ 109,091,732	$ 117,993,617	$ 507,415,639
% Change	18.13%	8.16%	8.16%	8.16%	8.16%	
Cost PMPM	$ 251.98	$ 262.06	$ 272.54	$ 283.45	$ 294.78	
% Change	12.50%	4.00%	4.00%	4.00%	4.00%	
All Other Aid Categories						
Member Months	11,028,135	11,469,260	11,928,031	12,405,152	12,901,358	59,731,936
% Change	5.00%	4.00%	4.00%	4.00%	4.00%	
Average Eligibles	919,011	955,772	994,003	1,033,763	1,075,113	
Payments	$ 2,242,361,107	$ 2,425,337,773	$ 2,623,245,336	$ 2,837,302,155	$ 3,068,826,011	$ 13,197,072,382
% Change	18.13%	8.16%	8.16%	8.16%	8.16%	
Cost PMPM	$ 203.33	$ 211.46	$ 219.92	$ 228.72	$ 237.87	
% Change	12.50%	4.00%	4.00%	4.00%	4.00%	
Total						
Member Months	11,484,322	11,945,975	12,423,814	12,920,767	13,437,597	62,212,475
% Change	5.05%	4.02%	4.00%	4.00%	4.00%	
Average Eligibles	957,027	995,498	1,035,318	1,076,731	1,119,800	
Payments	$ 2,342,617,264	$ 2,534,066,852	$ 2,740,846,707	$ 2,964,499,799	$ 3,206,402,982	$ 13,788,433,606
% Change	18.16%	8.17%	8.16%	8.16%	8.16%	
Cost PMPM	$ 203.98	$ 212.13	$ 220.61	$ 229.44	$ 238.61	
% Change	12.48%	3.99%	4.00%	4.00%	4.00%	

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Modernizing Michigan Medicaid
Budget Submission

Without Waiver
Fee for Service

	FY 2006	FY 2007	FY 2008	FY 2009	FY '2010	Total
Group 2 Under 21 - 19 & 20 year olds						
Member Months	56,308	59,686	62,670	65,177	68,436	312,278
% Change	10.00%	6.00%	5.00%	4.00%	5.00%	
Average Eligibles	4,692	4,974	5,223	5,431	5,703	
Payments	$ 15,682,507	$ 17,454,630	$ 19,243,729	$ 21,014,152	$ 23,168,103	$ 96,563,122
% Change	12.75%	10.24%	8.16%	8.16%	8.16%	
Cost PMPM	$ 278.51	$ 292.44	$ 307.06	$ 322.42	$ 338.54	
% Change	2.50%	5.00%	5.00%	5.00%	5.00%	
Caretaker Relatives						
Member Months	195,768	203,599	211,743	220,212	229,021	1,060,343
% Change	5.00%	4.00%	4.00%	4.00%	4.00%	
Average Eligibles	16,314	16,967	17,645	18,351	19,085	
Payments	$ 74,560,250	$ 81,419,793	$ 88,910,414	$ 97,090,172	$ 106,022,467	$ 448,003,095
% Change	8.15%	8.16%	8.16%	8.16%	8.16%	
Cost PMPM	$ 380.86	$ 399.90	$ 419.90	$ 440.89	$ 462.94	
% Change	3.00%	5.00%	5.00%	5.00%	5.00%	
All Other Aid Categories						
Member Months	6,491,717	6,751,386	7,021,441	7,302,299	7,594,391	35,161,234
% Change	5.00%	4.00%	4.00%	4.00%	4.00%	
Average Eligibles	540,976	562,615	585,120	608,525	632,866	
Payments	$ 3,691,733,546	$ 4,031,373,032	$ 4,402,259,351	$ 4,807,267,212	$ 5,249,535,795	$ 22,182,168,937
% Change	7.62%	8.16%	8.16%	8.16%	8.16%	
Cost PMPM	$ 568.68	$ 597.12	$ 626.97	$ 658.32	$ 691.24	
% Change	2.50%	5.00%	5.00%	5.00%	5.00%	
Total						
Member Months	6,743,793	7,014,671	7,295,855	7,587,689	7,891,848	36,533,855
% Change	5.04%	4.02%	4.01%	4.00%	4.01%	
Average Eligibles	561,983	584,556	607,988	632,307	657,654	
Payments	$ 3,781,976,302	$ 4,130,247,455	$ 4,510,413,494	$ 4,925,371,536	$ 5,378,726,365	$ 22,726,735,152
% Change	7.66%	9.21%	9.20%	9.20%	9.20%	
Cost PMPM	$ 560.81	$ 588.80	$ 618.22	$ 649.13	$ 681.55	
% Change	2.49%	4.99%	5.00%	5.00%	5.00%	

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Modernizing Michigan Medicaid
Budget Submission

With Waiver - Managed Care

	FY 2006	FY 2007	FY 2008	FY 2009	FY '2010	Total
Federally Mandated Rate Methodology (waive actuarial soundness)						
Member Months	11,484,322	11,943,694	12,421,442	12,918,300	13,435,032	62,202,790
% Change	5.00%	4.00%	4.00%	4.00%	4.00%	
Average Enrollment	957,027	995,308	1,035,120	1,076,525	1,119,586	
Cost	$ 2,082,699,216	$ 2,274,307,544	$ 2,459,891,040	$ 2,660,618,149	$ 2,877,724,590	$ 12,355,240,539
% Change	5.05%	9.20%	8.16%	8.16%	8.16%	
PMPM	$ 181.35	$ 190.42	$ 198.04	$ 205.96	$ 214.20	
% Change	0.00%	5.00%	4.00%	4.00%	4.00%	
Freeze Enrollment for Able Bodied aged 19 & 21						
Member Months	24,665	64,961	125,711	130,739	135,968	482,044
Average Enrollment	2,055	5,413	10,476	10,895	11,331	
Savings	$ 2,699,256	$ 7,464,535	$ 15,023,017	$ 16,248,895	$ 17,574,805	$ 59,010,508
PMPM	$ 109.44	$ 114.91	$ 119.50	$ 124.29	$ 129.26	
Eliminate Retroactive Eligibility						
Member Months	-	-	-	-	-	-
Savings	$ -	$ -	$ -	$ -	$ -	$ -
PMPM	$ 600.00	$ 630.00	$ 655.20	$ 681.41	$ 708.66	
Benefit Reductions for Caretakers and Able Bodied aged 19 & 20						
Member Months	431,522	411,754	370,073	384,876	400,271	1,998,495
Average Enrollment	35,960	34,313	30,839	32,073	33,356	
Cost	$ 4,902,786	$ 4,912,104	$ 4,635,603	$ 5,062,078	$ 5,527,789	$ 25,040,360
PMPM	$ 11.36	$ 11.93	$ 12.53	$ 13.15	$ 13.81	
% Change		5.00%	5.00%	5.00%	5.00%	
Net With Waiver						
Member Months	11,459,657	11,878,734	12,295,732	12,787,561	13,299,063	61,720,746
Average Enrollment	954,971	989,894	1,024,644	1,065,630	1,108,255	
Cost	$ 2,075,097,174	$ 2,261,930,905	$ 2,440,232,420	$ 2,639,307,176	$ 2,854,621,996	$ 12,271,189,671
PMPM	$ 181.08	$ 190.42	$ 198.46	$ 206.40	$ 214.65	
% Change	-0.15%	5.16%	4.22%	4.00%	4.00%	

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Modernizing Michigan Medicaid
Budget Submission

With Waiver - Fee for Service

	FY 2006	FY 2007	FY 2008	FY 2009	FY '2010	Total
Trended Fee for Service						
Member Months	6,743,793	7,014,671	7,295,855	7,587,689	7,891,848	36,533,855
% Change	5.04%	4.02%	4.01%	4.00%	4.01%	
Average Enrollment	561,983	584,556	607,988	632,307	657,654	
Cost	$ 3,781,976,302	$ 4,130,247,455	$ 4,510,413,494	$ 4,925,371,536	$ 5,327,721,859	$ 22,675,730,646
% Change	7.66%	9.21%	9.20%	9.20%	8.17%	
PMPM	$ 560.81	$ 588.80	$ 618.22	$ 649.13	$ 675.09	
% Change	2.49%	4.99%	5.00%	5.00%	4.00%	
Freeze Enrollment for Able Bodied aged 19 & 21						
Member Months	12,046	31,725	62,670	65,177	68,436	240,055
Average Enrollment	1,004	2,644	5,223	5,431	5,703	
Savings	$ 3,354,902	$ 9,276,911	$ 19,241,382	$ 21,011,589	$ 22,944,655	$ 75,829,440
PMPM	$ 278.51	$ 292.42	$ 307.02	$ 322.38	$ 335.27	
Eliminate Retroactive Eligibility						
Member Months	47,088	48,979	50,943	52,980	55,104	255,095
Savings	$ 28,252,800	$ 30,854,518	$ 33,694,503	$ 36,794,397	$ 39,800,107	$ 169,396,324
PMPM	$ 600.00	$ 629.95	$ 661.42	$ 694.49	$ 722.27	
Benefit Reductions for Caretakers and Able Bodied aged 19 & 20						
Member Months	240,030	231,560	211,743	220,212	229,021	1,132,566
Average Enrollment	20,003	19,297	17,645	18,351	19,085	
Cost	$ 2,879,414	$ 2,916,697	$ 2,800,436	$ 3,058,076	$ 3,339,419	$ 14,994,042
PMPM	$ 12.00	$ 12.60	$ 13.23	$ 13.89	$ 14.58	
% Change		5.00%	5.00%	5.00%	5.00%	
Net With Waiver						
Member Months	6,684,659	6,933,967	7,182,241	7,469,531	7,768,308	36,038,706
Average Enrollment	557,055	577,831	598,520	622,461	647,359	
Cost	$ 3,747,489,186	$ 4,087,199,329	$ 4,454,677,174	$ 4,864,507,474	$ 5,261,637,678	$ 22,415,510,841
PMPM	$ 560.61	$ 589.45	$ 620.23	$ 651.25	$ 677.32	
% Change	2.45%	5.14%	5.22%	5.00%	4.00%	

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Modernizing Michigan Medicaid
Budget Submission

Budget Neutrality Calculation

With Waiver	FY 2006	FY 2007	FY 2008	FY 2009	FY '2010	Total
Managed Care	$ 2,075,097,174	$ 2,261,930,905	$ 2,440,232,420	$ 2,639,307,176	$ 2,854,621,996	$ 12,271,189,671
FFS	$ 3,747,489,186	$ 4,087,199,329	$ 4,454,677,174	$ 4,864,507,474	$ 5,261,637,678	$ 22,415,510,841
Total	$ 5,822,586,360	$ 6,349,130,234	$ 6,894,909,594	$ 7,503,814,649	$ 8,116,259,674	$ 34,686,700,511
Without Waiver						
Managed Care	$ 2,342,617,264	$ 2,534,066,852	$ 2,740,846,707	$ 2,964,499,799	$ 3,206,402,982	$ 13,788,433,605
FFS	$ 3,781,976,302	$ 4,130,247,455	$ 4,510,413,494	$ 4,925,371,536	$ 5,378,726,365	$ 22,726,735,152
Total	$ 6,124,593,567	$ 6,664,314,307	$ 7,251,260,202	$ 7,889,871,334	$ 8,585,129,348	$ 36,515,168,757
Difference						
Managed Care	$ (267,520,090)	$ (272,135,947)	$ (300,614,287)	$ (325,192,623)	$ (351,780,987)	$ (1,517,243,935)
FFS	$ (34,487,116)	$ (43,048,126)	$ (55,736,320)	$ (60,864,062)	$ (117,088,687)	$ (311,224,311)
Total	$ (302,007,207)	$ (315,184,073)	$ (356,350,607)	$ (386,056,685)	$ (468,869,674)	$ (1,828,468,246)

Attachment C - 8

Modernizing Michigan Medicaid
Budget Submission

Budget Neutrality - Impact by Cagetory

Waive Federally Mandated Rate Methodology	FY 2006	FY 2007	FY 2008	FY 2009	FY '2010	Total
Managed Care Only	$ 259,918,048	$259,759,308	$280,955,668	$303,881,650	$328,678,393	$1,433,193,067
Eliminate Retroactive Eligibility						
Managed Care	$ -	$ -	$ -	$ -	$ -	$ -
FFS	$ 28,252,800	$ 30,854,518	$ 33,694,503	$ 36,794,397	$ 39,800,107	$ 169,396,324
Total	$ 28,252,800	$ 30,854,518	$ 33,694,503	$ 36,794,397	$ 39,800,107	$ 169,396,324
Freeze Enrollment for Able Bodied aged 19 & 21						
Managed Care	$ 2,699,256	$ 7,464,535	$ 15,023,017	$ 16,248,895	$ 17,574,805	$ 59,010,508
FFS	$ 3,354,902	$ 9,276,911	$ 19,241,382	$ 21,011,589	$ 22,944,655	$ 75,829,440
Total	$ 6,054,159	$ 16,741,446	$ 34,264,399	$ 37,260,484	$ 40,519,460	$ 134,839,948
Benefit Reductions for Caretakers and Able Bodied aged 19 & 20						
Managed Care	$ 4,902,786	$ 4,912,104	$ 4,635,603	$ 5,062,078	$ 5,527,789	$ 25,040,360
FFS	$ 2,879,414	$ 2,916,697	$ 2,800,436	$ 3,058,076	$ 3,339,419	$ 14,994,042
Total	$ 7,782,200	$ 7,828,801	$ 7,436,038	$ 8,120,154	$ 8,867,208	$ 40,034,402
Total	$ 302,007,207	$315,184,073	$356,350,607	$386,056,685	$417,865,168	$1,777,463,740
% Mandated Methodology	86.06%	82.42%	78.84%	78.71%	78.66%	80.63%
% Other Factors	13.94%	17.58%	21.16%	21.29%	21.34%	19.37%

Attachment D

Modernizing Michigan Medicaid Waiver Proposal Comments

The following is a compilation of the questions and comments received by the Department of Community Health related to the section 1115 "Modernizing Michigan Medicaid" waiver proposal. These comments were provided during the public forum held on May 4, 2005 and through the MMM Waiver e-mail box. Details that are unavailable at this time will be provided with opportunity for further comment during the public comment period of the policy promulgation process.

Questions	Responses
Prescriptions	
1. Is a 90-day prescription for maintenance medications considered one or three scripts under the waiver?	A 90-day prescription for maintenance meds is considered one prescription. Prescription drugs identified as maintenance medications on the Department's PBM website (www.michigan.fhsc.com) will be recognized as such under this waiver.
2. What is the rationale in limiting prescriptions to four a month?	A prescription drug monthly maximum was developed as a cost-savings measure while maintaining the benefit.
3. How will the proposed cap on prescriptions impact medications with prior authorization?	Even though a medication may have previously received prior authorization, the four-prescription limit will be imposed.
4. Will the managed care carved out drugs (e.g. HIV and anti-psychotics) be included in the four-prescription limit?	Yes.
Managed Care Regulations	
1. How can the Medicaid Health Plans (MHPs) offer a limited benefit package under the current HMO regulations?	The Office of Financial and Insurance Services (OFIS) has rendered an opinion to DCH stating that HMOs are permitted to provide a limited benefit package for Medicaid beneficiaries.
Eligibility and Enrollment	
1. Currently, the only low-income health assistance available to individuals with income from 150-200% of Federal Poverty Level (FPL) is through County Health Plans in the counties that offer this type of program. Will the state find a way to implement a sliding-scale plan for these low-income working adults?	There are currently no plans for eligibility expansion to this age group under this waiver.
2. What groups of persons will have additional coverage under this waiver proposal?	There is no additional expansion planned under the MMM waiver. Program eligibility will expand to the extent that the program can afford to provide benefits for the projected 70,000 individuals that will become eligible annually under the existing criteria.
3. Given the previous lawsuit against the state relative to the caretaker relative benefit, why does the state think it will be successful this time around?	The state is asking for benefit changes that will be applied to optional populations versus elimination of the coverage group.
4. What program types of the 19 and 20-year-olds will be targeted for elimination?	There will be an eligibility freeze on the under 21 aid category, Program Q, scope 2. The freeze will apply only to 19 and 20-year-olds who are in this group. Department wards and Title IV-E are not impacted by the enrollment freeze.

Modernizing Michigan Medicaid Waiver Proposal Comments

Questions	Responses
Managed Care Enrollment	
1. Would this waiver remove 19 and 20-year-old pregnant women from the MHPs?	This waiver is not applicable to pregnant women, so the current rules for pregnant women and managed care would continue to apply.
2. Please identify the number of individuals per MHP that will be impacted by the reduction proposal.	The number of persons impacted by benefit restrictions is 60,000, of which nearly 75% are enrolled in managed care. MHP specific numbers will be shared directly with the respective MHPs.
Federally Mandated Rate Methodology	
1. If the waiver of actuarial sound rates is granted, it is likely the MHPs will reduce coverage and deny access. Has the state figured out how to protect beneficiaries?	There should be no denial of access to care or benefit reduction as a result of this waiver aside from the services identified in the waiver proposal. Beneficiaries who are denied benefits by a MHP have the right to file a grievance with the respective health plan and/or file a request for an administrative hearing with the Department's Administrative Tribunal.
Hospital Benefit Limitations	
1. When does the one-year period for the 20-day limit begin? Does the year period relate to the calendar year, the state fiscal year, the beneficiary's eligibility year, or a period in which a patient is initially hospitalized?	Details of implementation are yet to be determined and will be provided for public comment in the policy promulgation process.
2. Are psychiatric hospitalizations exempt from the 20-day limit?	Psychiatric inpatient hospitalizations are exempt from the limit because of a separate funding source.
3. What is the reimbursement for a partially covered hospitalization? For example, if a patient has a 15-day stay followed by a 10-day stay, will a portion of the second day be covered or will a full DRG payment be made for the second hospitalization.	Details of implementation are yet to be determined and will be provided for public comment in the policy promulgation process.
4. Will hospitals be able to bill Medicaid beneficiaries for the uncovered hospital days?	Details of implementation are yet to be determined and will be provided for public comment in the policy promulgation process.
5. Are physician services provided in the hospital covered beyond the 20-day limit?	Details of implementation are yet to be determined and will be provided for public comment in the policy promulgation process.
6. Will the 20-day limit be applied based upon date of service, or upon date of invoice. For example, if a patient has two admissions, the first a 20-day stay and then a 10-day stay, and the claim for the second admission is received before the first, how will the 20-day limit be applied? We oppose any situation in which a paid claim is recovered, but are concerned about missing out on reimbursement for a more complicated case because a second, easier to bill claim gets submitted and paid promptly. We also believe that it is inappropriate to create the potential for manipulating reimbursement by pending or holding certain claims in order to use up the 20 day limit on less costly claims.	Details of implementation are yet to be determined and will be provided for public comment in the policy promulgation process.
8. Will non-covered days be included in the methodology for capital payments to hospitals?	No.

Modernizing Michigan Medicaid
Waiver Proposal Comments

Questions	Responses
9. In the event that an entire hospital stay will not be covered, we anticipate that the hospital will submit a claim to Medicaid for processing with $0 payment. For purposes of determining hospital GME payments, how will the Department treat those claims since the Medicaid GME payment formula includes calculation of case mix index. In a similar vein, how will these cases be handled for Medicaid disproportionate share and rebasing purposes?	Details of implementation are yet to be determined and will be provided for public comment in the policy promulgation process.
Due Process	
1. What process will be used to notify and give hearing rights to under 21 & Group 2 Caretaker Relative beneficiaries whose benefits will be cut under the waiver? What process will be used to ensure that these beneficiaries are reviewed for potential eligibility under the other eligibility categories that provide full benefits for them?	Each beneficiary will be given notice and provided rights in compliance with federal regulations at 42 CFR 431.200 et. sec. Any process developed will meet any and all requirements in the federal regulations.
Retroactive Enrollment	
1. If a potential Medicaid applicant experiences a catastrophic illness, and the illness is not confirmed for one to three months, would there be a process for special consideration to allow three months retroactive enrollment?	No special considerations have been discussed at this point.
2. Is there a process to ensure that Medicaid applications are processed for the month they are received (e.g. application received on Friday the 28th of the month)?	If the application is received and registered by the Department of Human Services on any day of a given month, eligibility will be made retroactive to the first day of that month.
3. Would the state consider granting eligibility using a specific number of days prior to application rather than using the beginning of the month? It would be impossible for providers to submit full applications for beneficiaries that receive services toward the end of the month.	The state plans to use the first day of the month in which the application is registered. Medicaid enrollment can only be implemented in full month increments. A minimal amount of information is required to register a case with the Department of Human Services.
4. Will retroactivity be available to pregnant women?	The retroactive enrollment change would apply to the entire Medicaid population.
5. How will the enrollment process work when a beneficiary eligible for waiver services becomes eligible for full Medicaid coverage? How will fee for service providers be reimbursed?	Details of implementation are yet to be determined and will be provided for public comment in the policy promulgation process.
6. How will the Department notify providers of limited or non-covered waiver benefits under the fee-for-service and managed care scenarios if retroactive coverage occurs?	Details of implementation are yet to be determined and will be provided for public comment in the policy promulgation process.
7. Can beneficiaries convert from full Medicaid coverage to the limited benefit waiver coverage in a retroactive manner?	Details of implementation are yet to be determined and will be provided for public comment in the policy promulgation process.
8. What is the payment policy for providers that provide services to a patient when the MSA system reflects full Medicaid eligibility and the patient is later determined to have only limited benefits under the waiver?	Details of implementation are yet to be determined and will be provided for public comment in the policy promulgation process.

Modernizing Michigan Medicaid Waiver Proposal Comments

Questions	Responses
9. If a patient is supposedly retroactively eligible to the first day of the month, it is unclear what the trigger date is to determine retroactive eligibility. Is it the admission date, the application date, or the date the application is logged in the local DHS office? We urge the Department to implement a policy that limits retroactive eligibility to 30 days retro from the date of admission as signed by the applicant. This would avoid caseload issues in the local office, time lapse between date of admission and date of application and provide uniform treatment to patients.	Medicaid enrollment can only be implemented in full month increments, so it is necessary to make enrollment effective on the first day of the month.
10. Governor Granholm has stated that proposed changes are not to impact children and the aged and disabled categories of Medicaid eligibility. When retroactive enrollment is terminated, all of these groups will be affected, especially the disabled population. Many times an emergency or catastrophic event leads to hospital admission and Medicaid eligibility. The process for applying for Medicaid because of a disability is a long process. This process will need to occur more quickly if retro enrollment is eliminated. Will denials result in appeals because of patients being unable to obtain medical records quickly enough? There are many consequences that will result in difficulties for the patients and hospitals.	Applicants and beneficiaries will be given notice and provided rights in compliance with federal regulations at 42 CFR 431.200 et. sec. Any process developed will meet any and all requirements in the federal regulations.
11. Will the Department of Human Services increase staff to accommodate the need for more timely eligibility and enrollment processing?	The Department of Community Health is unable to respond to questions related to Department of Human Services staffing.
12. Has the state considered shortening the retroactive period rather than eliminating it completely?	No.
Covered Benefits	
1. Will coverage for 19 & 20-year-olds and Caretaker Relatives be provided through managed care or fee-for-service?	Managed care enrollment requirements will continue as they currently do.
2. How will the state administer the benefit limitations?	Implementation details will be provided and comments accepted during the in the standard policy promulgation process.
3. Why are optional benefits being eliminated through this waiver?	The Medicaid program cannot be sustained in its current form with the funding that is available. The decision to eliminate the selected optional services was made with thought to those services that are most vital to beneficiaries.
4. Please define “all emergency room visits”. Specifically, does this include visits to the emergency room that are not for emergencies and are not billed as an emergency room visit?	Co-pay will apply to all services billed in the emergency department.
5. How will the co-pay for emergency room visits that result in an inpatient admission be treated?	No co-pay will be assessed for emergency department visits terminating in an inpatient stay.
6. Will the Medicaid system require an upgrade to track hospital days? It seems this would result in additional expense. Will hospitals know in advance the number of days available to treat a patient?	Details of implementation are yet to be determined and will be provided for public comment in the policy promulgation process.

Modernizing Michigan Medicaid Waiver Proposal Comments

Questions	Responses
Miscellaneous Questions	
1. What response has MDCH received from CMS regarding the proposal to waive actuarially sound rates?	Because the waiver has not been submitted to CMS for review, there has been no response from the federal government on this proposal.
2. Are there discussions with CMS regarding block grants?	There have been no discussions with the federal government regarding block grants.
3. Is the Department seeking to introduce managed care concepts to mental health, long-term care and Children's Special Health Care Services (CSHCS)?	Managed care has been an integral part of mental health since the Department received approval of a 1915(b) waiver in the late 1990s. Managed care pilots were implemented in the late 90s and then were phased out of the CSHCS program in 2004 due to administrative workload and cost concerns. The concept of managed care in the long-term-care setting has been explored by the current Long Term Care Task Force and will be addressed in its report.
4. How will the Medicare Part D impact Medicaid budget?	The "clawback" provision of the Medicare Modernization Act (MMA) passed by Congress requires that states send money to the federal government to provide funding support for coverage of the dual eligible population (Medicare-Medicaid) in the new Medicare Part D pharmacy benefit. Instead of saving the state money, current estimates indicate Michigan will spend significantly more in clawback and wrap-around (approximately $25.5 million) for Part D than it would have in the absence of the Medicare legislation. The state will lose the savings it has realized for this population through the aggressive rebate and volume purchasing programs Michigan has initiated for its pharmacy programs.
5. Are there discussions with Blue Cross Blue Shield of Michigan to take over any services for Medicaid?	No.
6. If state revenues remain flat while Medicaid caseloads and costs continue to increase, will Medicaid examine the cost savings that home and community based care could provide rather than costly nursing home services?	The Governor's Long Term Care Task Force is currently examining the long-term care system in this state and recommendations to the Governor related to this issue are forthcoming.
7. Has the state considered across the board cuts above 4% so as to not implement changes in eligibility that would hurt certain groups of eligibles?	Numerous options were considered in developing the budget. However the combination of eligibility changes, rate cuts, and federally mandated rate methodology modifications were determined to be the appropriate course to pursue at this time.
8. Has a lottery to support health care in Michigan been considered?	No.
9. What is plan B if the waiver is not approved for implementation by October 1 or not at all?	No alternative plan has been proposed at this time. The DCH budget is subject to legislative approval and the waiver proposal is derived from the executive budget proposed for fiscal year 2006.

Modernizing Michigan Medicaid
Waiver Proposal Comments

Comments

The following comments related to the MMM waiver document were submitted by various stakeholders. All comments were taken under advisement and will be considered by the Department as the waiver process continues.

1. **Federally Mandated Rate Methodology:**

   - Comments were submitted by several entities related to the proposed waiver of the federally mandated rate methodology for capitation rates paid to the Medicaid Health Plans (MHPs). Of primary concern is the financial viability of the MHPs, particularly those that have recently undergone a rehabilitation process in order to contract with the state in the last re-bid cycle. There is additional concern that access to and quality of services would suffer because of reduced capacity in the provider networks.
   - Hospitals have expressed dissatisfaction with the potential for reduced rates for the MHPs out of concern that they will see reduced reimbursement from the plans for services provided to Medicaid beneficiaries. There is also a concern for total default on payment from unstable MHPs, leaving the hospitals with complete liability for services provided. Additional hospital commentary included a statement that hospitals will receive reduced rates of reimbursement from MHPs for outpatient services because of the 4% fee for service rate cut, but the MHPs will not have an overall rate cut and will, therefore, benefit from the reduced rate paid to hospitals.
   - One of the Medicaid Health Plans commented that the proposal to suspend actuarial soundness requirements is "dangerous" to all of the health plans. Bids by the plans were made based on ability to provide quality care, an adequate network and actuarially approved solvency. It was stated that with the waiver, the State would be responsible for a program that cannot be certified as actuarially sound and it alters the contract agreed to by the health plans. Inadequate funding will affect the ability of the plans to perform according to the contractual requirements.
   - In 2004, MHPs bid for the right to provide services to Medicaid beneficiaries with the understanding that the capitation rates paid for services would be actuarially sound within a two-year period. Further delay of the rate increase will seriously compromise the financial positions of the MHPs. Business decisions were made during the bidding process based on information provided by the state during that period. If the MHPs found they could not continue to provide coverage under the new circumstances, many beneficiaries would be impacted.
   - A hospital commented that proposal to suspend the federally mandated rate methodology would create a "race to the bottom". This hospital expressed concern that this would result in more insolvencies and write-offs to providers.
   - There is concern that the MHPs that have not separated their commercial and Medicaid business will take action to split the business in the future.

- A hospital stated that two-thirds of Michigan hospitals are losing money and for the state to invoke a policy that will result in additional uncompensated care is "disturbing." The same hospital indicated it would support new revenue to fund the Medicaid program.

2. **Retroactive Enrollment:** The state received several comments regarding a request for waiver of the three-month retroactive enrollment requirement.

   - Hospitals commented that the anticipated savings the state expects to realize is grossly underestimated, and the financial impact on hospitals would be much greater. The hospitals commented that an additional unintended ramification would be the reduction in Medicare disproportionate share payments to the hospitals. There was also concern related to the ability of the Department of Human Services to process cases for patients admitted at the end of a month, particularly on a weekend.
   - The MHPs believe that the elimination of retro enrollment will result in a shift of costs from Medicaid to other payers of care and it will weaken the provider networks for managed care. There is also concern that this provision has the potential of delaying enrollment in the Children's Special Health Care Services program and adding costs to managed care.
   - Advocates have commented that elimination of retroactive enrollment will harm individuals who become disabled and incur large amounts of debt related to medical expenses. There is also concern for individuals losing jobs and for the elderly whose savings are depleted because of health care related debt. Also, unpaid debts may result in providers refusing to provide treatment or maintain care for a beneficiary undergoing treatment.
   - There is concern that elderly and disabled individuals in nursing homes may be involuntarily discharged as a result of no retroactive enrollment.
   - One MHP commented that waiver of the retroactive enrollment requirement will negatively impact relationships with providers, causing disenrollment from the program leading to additional access problems.
   - A comment was received that waiver of retroactive enrollment will cause the most harm for the fragile Medicaid population and result in restricted access to health care. There was also concern that long-term care facilities do not have the resources to absorb the losses that would result from the proposal.
   - Concern was expressed related to patients that present to hospitals claiming to have insurance but the verification process proves they do not. By the time coverage or lack thereof is discovered, it may be too late for the hospital to pursue Medicaid eligibility for these patients.

3. **Enrollment freeze for 19 & 20-year-olds:**

   - Hospitals commented that the enrollment freeze would reduce access to health care and increase uncompensated care.

- A comment was also provided that current state law prohibits the elimination of the medically needy category of eligibility for individuals under age 21.
- Elimination of coverage for 19 & 20-year-olds is bad health policy as it will increase the number of uninsured young adults in the state. This will drive up the cost of health care, as these individuals will not have timely access to medical care that could prevent more costly, hospital-based care for more serious and debilitating health problems.
- Federal Financial Participation (FFP) would end for mental health services for this group, shifting costs to the state.
- One hospital commented that freezing enrollment for 19 & 20-year-olds will add to the number of uninsured in the state, which will "shift more of the state's responsibility to a weakened health care delivery system."

4. **Benefit Limitation**:

- Hospitals expressed concern that limiting the inpatient hospital benefit will result in a reduction of the Medicare disproportionate share payments. If the 20-day limit is imposed, the rules could be written in a manner that would maintain Medicaid eligibility for all the days, thereby protecting the DSH funding. For example, if the state paid a per diem amount for days in excess of the 20-day limit, the vast majority of the savings could still be achieved, but the Medicare DSH days, and Medicare DSH funding for hospitals would be preserved.
- One MHP commented that the proposed benefit limitations would be difficult to administer. Because the health plans reimburse hospitals on a DRG basis, it will be difficult to determine reimbursement rates if admissions exceed the limit. The same plan commented that the prescription limitation would potentiate noncompliance with treatment plans, an issue health plans have aggressively been addressing. Further, the benefit limitations were not included in the rate methodology when health plan rates were determined. There is concern for how this would be addressed and how it will impact rates on other populations not included in the limitations.
- Patients who need more than four prescriptions per month may end up in the emergency room. This will end up costing the state more in emergency room care than it would in the original cost of prescriptions.

5. **Emergency Room (ER) Co-payment**:

- A waiver to impose a $10 ER co-payment on all emergency room visits violates federal law at 42 USC 1396o(a)(3). By law, the ER co-payments cannot exceed $6.00. The state cannot establish that non-emergency services are available and accessible to Medicaid beneficiaries in all parts of the state, and the state is unable to pay fee-for-service rates that would be adequate to assure that primary care is available within 30 miles of a beneficiary's home.

6. **Due Process/Notice and Appeal Rights:**

- The Department must provide opportunity to the caretaker relatives and 19 & 20-year-olds to have their eligibility for other categories of Medicaid reviewed before coverage is reduced. If eligibility for other categories is not established, beneficiaries must be given adequate notice and an opportunity for an administrative hearing, as well as time to seek medical advice, prior to benefit reduction.
- The Department should provide notice to beneficiaries not qualifying in another category of coverage. The Department should work with the medical community to identify the information that should be provided to individuals who lose coverage or have new benefit limitations imposed to reduce harm to the beneficiaries' health and welfare.
- The Department should develop materials to educate providers about the benefit changes for some Medicaid beneficiaries in order to make appropriate choices and recommendations in treatment.
- The Department should work with advocates to develop notices to new applicants determined eligible in a medically needy category of coverage to ensure they understand they have been denied coverage in other categories. Also it is important they are informed of the right to appeal the decision and to request eligibility in another category if circumstances change. The Department should work with DHS so that staff is made aware of the new coverage limitations so that eligibility for other categories will be checked.

7. **General Comments:** The following bullets summarize/paraphrase general comments received from various entities regarding multiple issues related to the waiver proposal:

   - Increasing the number of underinsured adults in Michigan undermines health policy objectives. Arbitrary limits on benefits, such as those proposed for prescription drugs and hospital days, will prevent beneficiaries from obtaining the services their physicians prescribe. Because the Department has taken other steps to address utilization issues with managed care and prior authorization requirements, the waiver restrictions will impact individuals with the greatest needs. Because these individuals will be considered "insured" by Medicaid, they will be unable to qualify for pharmaceutical company discount programs to obtain prescription drugs not covered because of the benefit limit.
   - Arbitrary limits will temporarily reduce costs but lead to undesirable outcomes.
   - Limiting prescription drugs will discourage the use of the most cost effective treatment for some conditions, and the number of avoidable hospitalizations will increase.
   - Limiting benefits for parents and caretaker relatives undermines human services policy objectives. The reduced benefit package may result in deteriorating health for these caretakers which in turn could result in their inability to continue in their roles as caretakers with the children forced into foster care. Many parents affected by the proposed cuts may not be able to continue employment if they are unable to access medical care. Therefore, cutting Medicaid services

may force these individuals back to the welfare rolls, increasing the Department of Human Services caseload.
- Family stability may be adversely impacted as the result of benefit cuts.
- The Department should work with advocates and providers to develop protections that will assure continuity of care for beneficiaries with unpaid medical bills as a result of waiver changes. This is especially important for individuals in nursing homes.
- The state budget is being balanced at the expense of Michigan's hospitals and the vulnerable populations they serve.
- One MHP expressed the opinion that the financial impact of the waiver proposal on the federal government is unclear and the ability of the state to assess the proposal's success is not evident.
- The waiver proposal "does not modernize Medicaid; rather it ushers in substantial program cuts in eligibility, coverage and payment."
- Michigan's Medicaid program is under funded and this waiver proposal will exacerbate the problem.
- The state provided inadequate opportunity for public comment.
- Not enough implementation and operational details have been made available to adequately assess the impact on hospitals making it difficult to calculate the financial impact the waiver might have. There is particular concern in this regard related to the request for a waiver of retroactive enrollment.
- A comment received from the general public indicated a concern for the indigent and the nursing home and hospital industries if the waiver proposal were to be implemented.

8. **Recommendations:** The Michigan Association of Health Plans and its constituents have proposed the following recommendations in lieu of the proposed waiver components:

   - "The Medicaid Program should implement a series of policy and contract changes that will not only assure that the capitation rates paid to Medicaid health plans are actuarially sound, as required under federal regulations, but can extend the demonstrated cost savings to other areas of the state budget." To accomplish this recommendation, it is proposed that the state should change the underlying assumptions for the health plan rates. Proposed options include:
     - Benefit/coverage modifications similar to other product lines and other state programs;
     - Administrative, contract and policy changes that can reduce the underlying administrative requirements for managed care;
     - Reimbursement policy changes that can affect both the Medicaid fee-for-service program and managed care;
     - Incorporating additional features to the managed care program and benefiting through the HMO assessment used to underwrite Medicaid services; and

  - Extending managed care concepts of competition, best practices, evidence-based medicine, and outcome-based services elsewhere in health care services supported in different program areas of the state budget.

- "Assure that any future Medicaid fee-for-service provider rate increases are built into the rates paid to Medicaid health plans in order to have the Medicaid managed care program remain actuarially sound." Because Medicaid health plans are required to reimburse fee-for-service rates to out-of-network providers, health plans have experienced rate creep. To address this issue, it was proposed that the Michigan Association of Health Plans work with the Administration and the legislature to develop a formula addressing the issue. It was also suggested that Medicaid policy changes and/or changes to the health plan contract could be made to exempt health plans from paying fee-for-service rates that change during a contract period.
- "Continued collaboration on efforts to reduce Medicaid emergency department utilization of non-emergent services and develop and implement incentives for services to be provided in alternative settings."
- "Full implementation of electronic billing and communication in the Medicaid program for all payers and providers." The MAHP has suggested that expansion of electronic billing will achieve financial savings for the Medicaid program and that permission to require electronic billing be sought.
- "Ongoing identification and implementation of cost avoidance opportunities through revision of contract administrative requirements or change in DCH operations and expansion of the concept of "deeming" that would accept national accreditation as compliance with the same or similar state requirements." The MAHP states that unnecessary regulatory requirements result in additional costs that could be redirected to sustain services if the requirements were eliminated.